SECTION 2
UB-92 CLAIM FILING INSTRUCTIONS
INPATIENT HOSPITAL

The following instructions pertain to inpatient hospital claims which are being filed to Medicaid on a paper UB-92 claim form. The requirements for filing an electronic version of the UB-92 claim form for inpatient services are slightly different. If filing claims electronically via the Infocrossing Internet service at www.emomed.com, refer to the help link at the bottom of the electronic UB-92 claim form. If filing electronically using the 837 Institutional Claim, refer to the Implementation Guide for information.

The UB-92 paper claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims for hospital inpatient care are mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5100
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at www.dss.mo.gov/dms.

NOTE: An asterisk (*) beside field numbers indicates required fields on all inpatient UB-92 forms. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
1.*	Unlabeled Field	Enter the provider name and address exactly as it appears on the provider label. The 9-digit provider number **must** either be entered in this field or in field 51. For convenience, affix the provider label issued by the fiscal agent. This preprinted label contains all the required information. When affixing the label, do **not** cover other fields. Claim forms may be ordered from the fiscal agent with this required information preprinted on the form.
2.	Unlabeled Field	Leave blank.

3.	Patient Control Number	Enter the patient's account number assigned by the hospital.
4.*	Type of Bill	The required three digits in this code identify the following: 1st digit: type of facility 2nd digit: bill classification 3rd digit: frequency The allowed values for each of the digits found in the type of bill are: Type of Facility: 1st digit (1) Hospital Bill Classification: 2nd digit (1) Inpatient (Including Medicare Part A) (2) Inpatient (Medicare Part B only) Frequency: 3rd digit (1) Admit thru Discharge Claim (2) Interim Bill - first claim (3) Interim Bill - continuing claim (4) Interim Bill - last claim
5.	Federal Tax Number	Leave blank.
6.*	Statement Covers Period (from and through dates)	Indicate the beginning and ending dates being billed on this claim form. Enter in MMDDYY numeric format. It **should** include the discharge date as the thru date when billing for the entire stay. Unless noted below, it **should** include all days of the hospitalization. It **should not** include date(s) of patient ineligibility. It **should not** include inpatient days that were **not** certified by the Medicaid certifying agent, such as pre-op days or days beyond the certified through date.
7.*	Covered Days	Enter the number of days shown in field 6, minus the date of discharge. The discharge date is **not** a covered day and should **not** be included in the calculation of field 7. The

		through date of service in field 6 is included in the covered days, if the patient status code in field 22 is equal to “30 - still a patient”. **NOTE:** The units entered in this field **must** be equal to the number of days in “Statement Covers Period” less the day of discharge. If the patient status is “30 - still a patient”, units entered include the through day.
8.**	Non-covered Days	If applicable, enter the number of non-covered days. An example of non-covered days is those days for which the patient is not eligible. **NOTE:** The total units entered in fields 7 and 8 **must** be equal to the total accommodation units listed in field 46.
9.	Coinsurance Days	Leave blank.
10.	Lifetime Reserve Days	Leave blank.
11.	Unlabeled Field	Leave blank.
12.*	Patient Name	Enter the patient’s name as shown on the Medicaid ID card in the following format: last name, first name.
13.	Patient Address	Leave blank.
14.	Patient Birth Date	Leave blank.
15.	Patient Sex	Leave blank.
16.	Patient Marital Status	Leave blank.
17.*	Admission Date	Enter the date the patient was admitted for inpatient care in MMDDYY format. This should be the **actual** date of admission regardless of the patient’s eligibility status on that date or the Medicaid utilization review agent’s certification/denial of the admission date.
18.	Admission Hour	Leave blank.

19.* Type of Admission

Enter the appropriate type of admission. The allowed values are:

1 - Emergency
2 - Urgent
3 - Elective
4 - Newborn

20.** Source of Admission (SRC)

If this is a transfer admission, complete this field. The allowed values are:

Type of Admission 1, 2, and 3 values are:
1 - Physician referral
2 - Clinic Referral
3 - HMO referral
4 - Transfer from a hospital
5 - Transfer from a skilled nursing facility
6 - Transfer from another health care facility
7 - Emergency room
8 - Court/law enforcement
9 - Information not available
A - Transfer from a critical access hospital

Type of Admission 4 values are:
1 - Normal Delivery
2 - Premature delivery
3 - Sick baby
4 - Extramural birth

21. Discharge Hour

Leave blank.

22.* Status

Enter the 2-digit patient status code that best describes the patient's discharge status.

Common values are:
01 - Discharged to home or self-care
02 - Discharged/transferred to another short-term general hospital for inpatient care
03 - Discharged/transferred to skilled nursing facility
04 - Discharged/transferred to an intermediate care facility

05 - Discharged/transferred to another type of institution for inpatient care
06 - Discharged/transferred to home under care of an organized home health service
07 - Left against medical advice, or discontinued care
08 - Discharged/transferred to home under care of Home IV provider
20 - Expired
30 - Still a patient
50 - Hospice - home
51 - Hospice - medical facility
62 - Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65 - Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

23. Medical/Health Record Number

Enter the number that identifies the patient's medical record within the facility.

24.*-30.* Condition Codes

Enter the appropriate two-character condition code(s). The values applicable to Medicaid are:

C1 - Approved as billed. Indicates the facility's utilization review authority has certified all the days billed.
C3 - Partial Approval. The stay being billed on this claim has been approved by the UR as appropriate; however, some portion of the days billed have been denied. **If C3 is entered, field 36 must be completed.**

NOTE: Code C1 or C3 is required.

A1 - EPSDT/Healthy Children and Youth. If this hospital stay is the result of an HCY referral or is an HCY related stay, this condition code **must** be entered on the claim.

A4 - Family Planning. If family planning services occurred during the inpatient stay, this condition code **must** be entered.

31. Unlabeled Field — Leave blank.

32.** - 35.** Occurrence Codes — If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim:

- 01 - Auto accident
- 02 - No fault insurance
- 03 - Accident/Tort Liability
- 04 - Accident/Employment Related
- 05 - Accident/No medical or liability coverage
- 06 - Crime Victim
- 42 - To be entered when " through" date in field 6 is **not** equal to the discharge date and the frequency code in field 4 indicates that this is a final bill.

36.** Occurrence Span — Is required if C3 is entered in fields 24-30. Enter "MO" and the first and last days that were approved by the hospital's utilization review department.

37.** Internal Control Number (Medicaid resubmission) — For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim indicating the claim was initially submitted within the 12 month timely filing limit.

38. Unlabeled Field — Leave blank.

39-41. Value Codes and Amounts — Leave blank.

42.* Revenue Code — Enter the appropriate 4-digit revenue code. Section 3 of this book lists the covered and non-covered inpatient hospital revenue codes. List the accommodation revenue codes first in chronological order. Ancillary codes should be shown in numerical order.

Show duplicate revenue codes for accommodations when the rate differs or when

transfers are made back and forth, e.g., general to ICU to general.

When billing for a private room that was medically necessary, a completed *Certificate of Medical Necessity* form **must** be submitted unless the hospital has only private rooms. The private room rate times the number of days is entered as the charge.

If the patient requested a private room, which is non-covered, multiply the private room rate by the number of days for the total charge in field 47. Enter the difference between the private room total charge and the semi-private room total charge in field 48, non-covered charges.

After all revenue codes are shown, skip a line and enter revenue code 0001 which represents the total charges.

43. Revenue Description — Leave blank.

44.* HCPCS/Rates — Enter the daily room and board rate to coincide with the accommodation revenue code. When multiple rates exist for the same accommodation revenue code, use separate lines to report each rate.

45. Service Date — Leave blank.

46.* Service Units — Enter the number of units for the accommodation line(s) only. This field should show the total number of days hospitalized, including covered and non-covered days.

NOTE: The number of units in fields 7 and 8 **must** equal the number of units in this field.

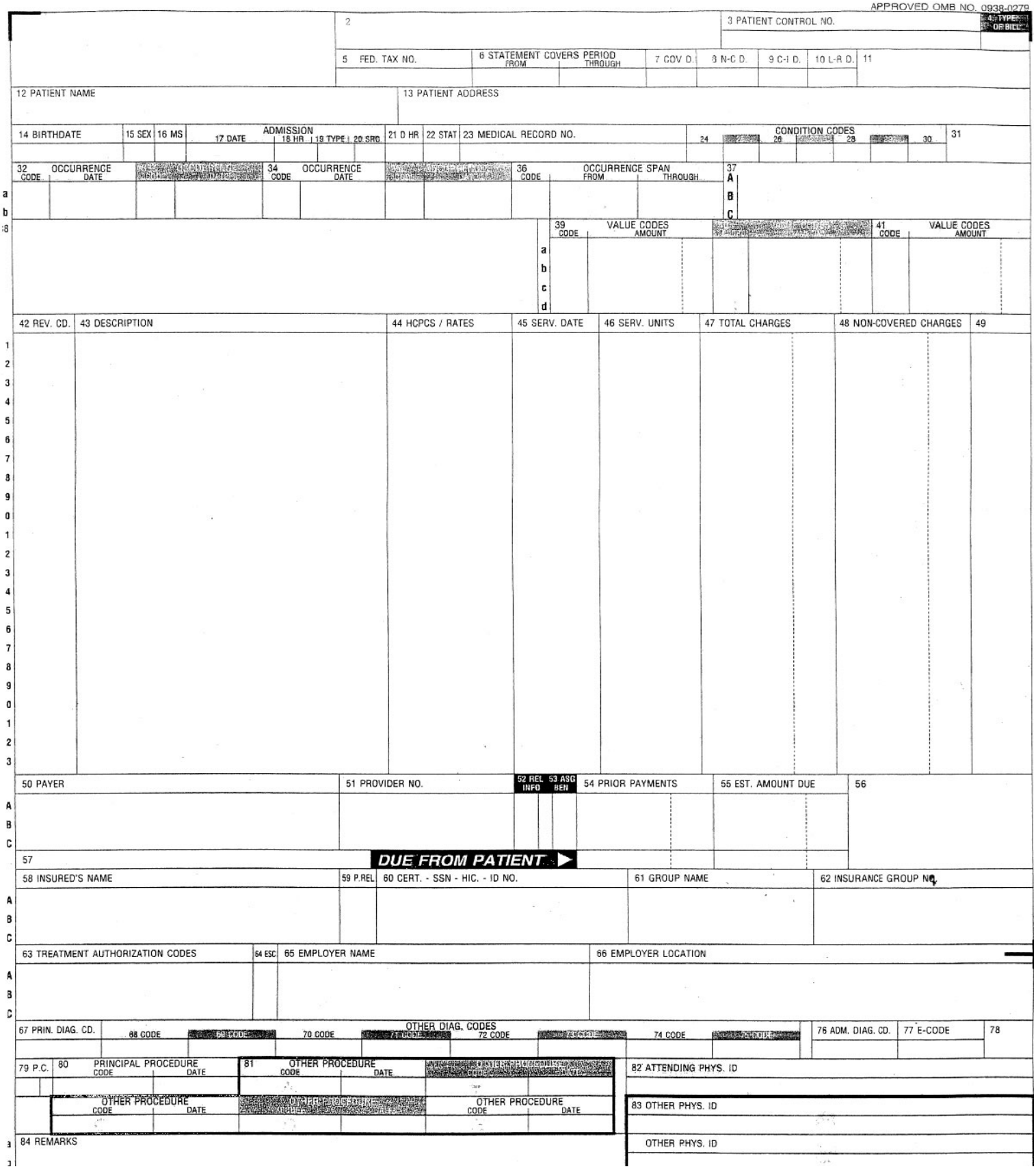
47.* Total Charges — Enter the total charge for each revenue code listed. When all charge(s) are listed, skip one line and state the total of these charges to correspond with revenue code 0001.

		NOTE: The room rate multiplied by the number of units **must** equal the charge entered for room accommodation(s).
48.**	Non-covered Charges	Enter any non-covered charges. This includes all charges incurred during those non-covered days entered in field 8. If Medicare Part B was billed, those Part B charges should be shown as non-covered. The difference in charges for private versus non-private room accommodations when the private room was **not** medically necessary should be shown as non-covered in this field.
49.	Unlabeled Field	Leave blank.
50.*	Payer Identification	Indicate if the patient has a secondary payer by listing the name of the payer on the first line. The primary payer is always listed first; e.g., if the patient has insurance, the insurance plan is the primary payer and “Medicaid” is listed last.
51.**	Provider Number	If the Medicaid provider number was **not** entered in field 1, it must be shown here.
52.	Release of Information Certification Indicator	Leave blank.
53.	Assignment of Benefits Certification of Indicator	Leave blank.
54.**	Prior Payments	Enter the amount received for each payer(s). Previous Medicaid payments, Medicare payments, cost sharing and co-pay amounts are **not** to be entered in this field. This field is required if other payer information was indicated in field 50. Payments **must** correspond with the appropriate payer entered in field 50. [See Note (1)]
55.	Estimated Amount Due	Leave blank.
56.	Unlabeled Field	Leave blank.
57.	Unlabeled Field	Leave blank.

58.**	Insured's Name	Complete if the insured's name is different from the patient's name. [See Note (1)]
59.	Patient's Relationship to Insured	Leave blank.
60.*	Certificate/SSN Number/ Health Insurance Claim/ Identification Number	Enter the patient's eight-digit Medicaid number as shown on the Medicaid ID card. If insurance was indicated in field 50, enter the insurance number to correspond with the order shown in field 50.
61.**	Group Name	If insurance is shown in field 50, state the name of the group or plan through which the insurance is provided to the insured. [See Note (1)]
62.**	Insurance Group Number	If insurance is shown in field 50, state the number assigned by the insurance company to identify the group under which the individual is covered. [See Note (1)]
63.**	Treatment Authorization Code	For claims requiring certification, enter the unique 7-digit certification number provided by the Medicaid utilization review agent.
64.	Employment Status Code	Leave blank.
65.	Employer Name	Leave blank.
66.	Employer Location	Leave blank.
67.*	Principal Diagnosis Code	Enter the complete ICD-9-CM diagnosis code for the condition established after study to be chiefly responsible for the admission.
68.**-75.**	Other Diagnosis Codes	Enter any additional ICD-9-CM diagnosis codes that have an effect on the treatment received or the length of stay.
76.	Admitting Diagnosis	Leave blank.
77.	E-Code	Leave blank.
78.	Unlabeled Field	Leave blank.

79.	PC (Procedure Coding Method)	Leave blank.
80.**	Principal Procedure Code and Date	Enter the complete ICD-9 procedure code for the principal procedure and the date the procedure was performed. Only the month and day are required. Do **not** use the decimal point when entering the code on the claim.
81.**	Other Procedure Codes and Dates	If more than one procedure was performed, enter the appropriate ICD-9 procedure code(s) and date(s) the procedure(s) was (were) performed. Only the month and day are required. Do **not** use the decimal point when entering the code(s) on the claim.
82.*	Attending Physician ID	Enter the attending physician's Missouri (or other state) license number, Missouri Medicaid provider number or UPIN number.
83.**	Other Physician ID	Complete, if applicable. Enter the admitting physician's Missouri (or other state) license number, Missouri Medicaid provider number or UPIN number.
84.**	Remarks	Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc.
85.	Provider Representative	Leave blank.
86.	Date	Leave blank.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved, **LEAVE IT BLANK**. If Medicare, Medicaid, employer's name or other information appears in this field, the claim will deny.


APPROVED OMB NO. 0938-0279
2
3 PATIENT CONTROL NO.
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7 COV D.
8 N-C D.
9 C-I D.
10 L-R D.
11
12 PATIENT NAME
13 PATIENT ADDRESS
14 BIRTHDATE
15 SEX
16 MS
17 DATE
ADMISSION
18 HR
19 TYPE
20 SRC
21 D HR
22 STAT
23 MEDICAL RECORD NO.
24
CONDITION CODES
26
28
30
31
32 CODE OCCURRENCE DATE
34 CODE OCCURRENCE DATE
36 CODE OCCURRENCE SPAN FROM THROUGH
37
A
B
C
39 CODE VALUE CODES AMOUNT
41 CODE VALUE CODES AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATES
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
50 PAYER
51 PROVIDER NO.
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56
57
DUE FROM PATIENT
58 INSURED'S NAME
59 P.REL
60 CERT. - SSN - HIC. - ID NO.
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 ESC
65 EMPLOYER NAME
66 EMPLOYER LOCATION
67 PRIN. DIAG. CD.
OTHER DIAG. CODES
68 CODE
70 CODE
72 CODE
74 CODE
76 ADM. DIAG. CD.
77 E-CODE
78
79 P.C.
80 PRINCIPAL PROCEDURE CODE DATE
81 OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
82 ATTENDING PHYS. ID
83 OTHER PHYS. ID
84 REMARKS
OTHER PHYS. ID